

Treating Substance Use Disorder in Older Adults

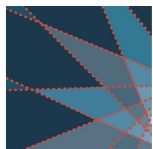
UPDATED 2020

TREATMENT IMPROVEMENT PROTOCOL

TIP 26

SAMHSA

Substance Abuse and Mental Health
Services Administration



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.

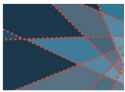
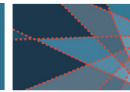


EXHIBIT 1.1. Key Terms

- **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

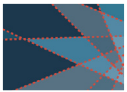
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- **Psychoactive substances:** Substances that can alter mental processes (e.g., cognition or affect; in other words, the way one thinks or feels). Also called psychotropic drugs, such substances will not necessarily produce dependence, but they have 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.

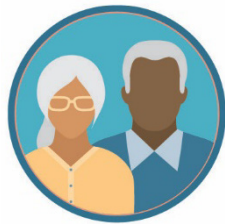
* The definitions of all terms marked with an asterisk correspond closely to those given in *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. This resource provides a great deal of useful information about substance misuse and its impact on U.S. public health. 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

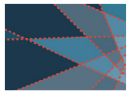
Healthcare and behavioral health service providers and caregivers must understand this diversity to provide culturally responsive services, including interventions and treatments for alcohol and other substance misuse.²⁶ Providers should also recognize differences between generations of older adults 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 NSDUH⁴³ 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?

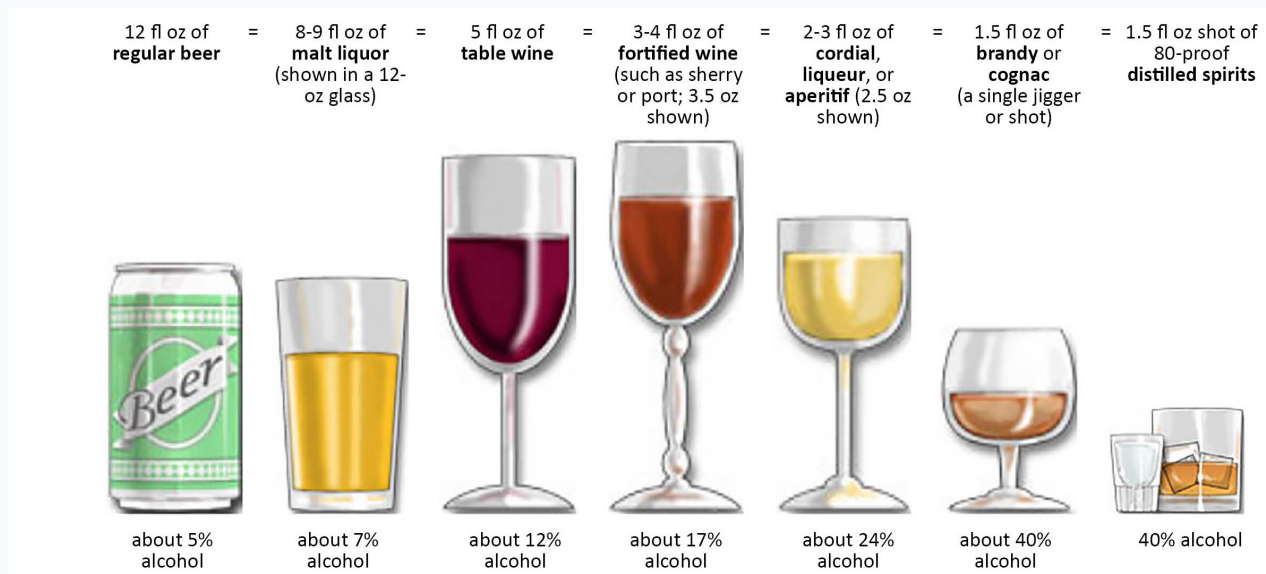


Image adapted from material in the public domain.⁴⁴

In healthcare settings, up to 15 percent of older patients may meet criteria for at-risk drinking.^{45,46,47} For example, one study⁴⁸ 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

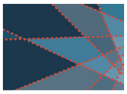
- While taking certain prescription medications (such as opioids or sedatives)
- Despite having a medical condition that drinking could worsen (like diabetes or heart disease)

- 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 Medications⁵⁸

- 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 accidentally 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, tranquilizers, 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

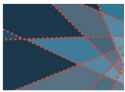
In 2016, the Food and Drug Administration (FDA) issued a warning about serious risks, including death, from combining opioids with benzodiazepines or other CNS depressants, and required boxed warnings for prescription opioids and benzodiazepines. FDA’s action was not meant to suggest that providers withhold 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.

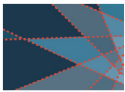


EXHIBIT 1.8. Barriers to Seeking Treatment

- **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 SCREENING¹¹⁹

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.

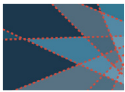


EXHIBIT 1.9. Characteristics of Early-Onset Versus Late-Onset Alcohol Misuse¹²⁶

- 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 adults¹²⁷
- 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 outcomes¹³⁰ 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.

ODU

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**

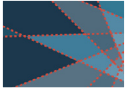
older adults with OUD. It may be preferable to methadone, because it is less likely to cause withdrawal symptoms, erectile dysfunction, and prolonged QT interval (see "Methadone" section). It may be safer than methadone for older adults with cardiovascular/respiratory disorders.¹⁵² A study of short-term 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



RESOURCE ALERT: METHADONE SAFETY

See *Methadone Safety: A Clinical Practice Guideline From the American Pain Society and College on Problems of Drug Dependence, in Collaboration With the Heart Rhythm Society* ([www.jpain.org/article/S1526-5900\(14\)00522-7/fulltext](http://www.jpain.org/article/S1526-5900(14)00522-7/fulltext)).

This guideline provides recommendations on the safe use of methadone and addresses the potential risks related to overdose and cardiac arrhythmias.

Naloxone

Naloxone does not treat OUD or pain by itself, but it can reverse potentially fatal opioid overdoses. It is so effective that WHO lists it as “an essential medication.”¹⁶⁶ Older adults are at increased risk of opioid overdose. Bodily changes that occur normally in aging cause older adults to experience a higher concentration of opioid metabolites than younger adults when the same dose is consumed.¹⁶⁷ **Low-dose naloxone is safe and effective in older adults** in case of opioid overdose.

Formal and Informal SUD Treatment Approaches

People can change their substance use at any age. Once substance misuse becomes apparent, hope for recovery should always follow. A wide range of professionals and providers across a variety of settings share the responsibility to help older clients achieve recovery.

Some studies suggest that older adults who enter specialized SUD treatment have better outcomes than younger adults.^{168,169,170,171}

However, many traditional SUD treatment programs do not serve many older adults (compared with the number of younger people they serve). In 2019, only about 23 percent of SUD treatment facilities had older adult-specific

programming.¹⁷² Thus, few studies with significant older populations have examined effectiveness of residential programming in this age group.

Older adults do best in SUD treatment programs that offer age-appropriate care with providers who are knowledgeable about aging issues.¹⁷³ In the community-based Geriatric Addictions Program, for older adults with SUDs and co-occurring mental disorders, a multidimensional approach connected more older adults to outpatient and inpatient treatment than did traditional assessment and referral. The multidimensional approach included geriatric care management assessment, motivational counseling, in-home counseling, and referral to aging services and addiction treatment.¹⁷⁴

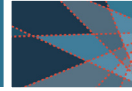
Many pathways lead to recovery, and many treatment options work for older adults (Exhibit 1.10).

EXHIBIT 1.10. Range of Intervention and Treatment Strategies for Older Adults

- Minimal advice
- Structured brief intervention protocols (e.g., SBIRT)
- Structured brief treatments
- Formal specialized treatments
- Relapse prevention programs

Few older adults who screen positive for substance misuse need specialized addiction treatment. Many can change their misuse through less intensive approaches,^{175,176} such as:

- Professional and personal advice and discussions.
- Education about alcohol misuse, drug use, and prescription medication misuse.
- Brief structured interventions and treatments (both individual and group).



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

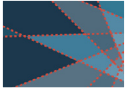
help all older clients receive the best possible care for substance misuse.

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	<p>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.</p> <p>Similarly, an older person who fears stigma that comes from hearing other people express these negative beliefs might not ask for help.</p>	<p>Choi et al. (2014)¹⁷⁷</p> <p>Blais et al. (2015)¹⁷⁸</p> <p>Crome (2013)¹⁷⁹</p>
Co-occurring physical and mental health conditions	<p>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.</p> <p>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.</p>	<p>Royal College of Psychiatrists (2015)¹⁸⁰</p> <p>Crome (2013)¹⁸¹</p> <p>Center for Behavioral Health Statistics and Quality (2020)¹⁸²</p> <p>Priester et al. (2016)¹⁸³</p>

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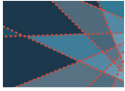
BARRIER	DEFINITION, DESCRIPTION, OR EXAMPLE OF BARRIER	SAMPLES OF RESEARCH
Lack of awareness on the part of older clients	<p>Older clients may not realize how much they are drinking or that their substance misuse is a problem.</p> <p>For instance, older people are affected by alcohol differently than 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.</p> <p>Some older adults think the amount of alcohol they drink is not risky although it exceeds recommendations for low-risk drinking.</p> <p>Sometimes a client's lack of awareness can result from cognitive impairment, making it hard for the client to self-monitor alcohol intake.</p>	<p>Sacco & Kuerbis (2013)¹⁸⁴</p> <p>Borok et al. (2013)¹⁸⁵</p> <p>Kuerbis et al. (2014)¹⁸⁶</p>
Family members' lack of awareness of older adults' misuse	<p>Adult children may not know how much their parent is drinking or that his or her substance misuse is harmful.</p> <p>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."</p>	<p>Royal College of Psychiatrists (2015)¹⁸⁷</p> <p>Briggs et al. (2011)¹⁸⁸</p>
Ageism	<p>"Ageism" refers to negative beliefs or attitudes about older people that lead to stereotyping or discrimination.</p> <p>An example of ageism is failing to screen a client in her 80s for SUDs because "people her age don't benefit from treatment."</p>	<p>Royal College of Psychiatrists (2015)¹⁸⁹</p> <p>Chrisler et al. (2016)¹⁹⁰</p>
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.	<p>Choi et al. (2014)¹⁹²</p> <p>Osborn et al. (2017)¹⁹³</p>
Limited mobility, transportation, or both	<p>Examples of these barriers are having difficulty walking or not having access to mobility assistance devices (like a walker or wheelchair).</p> <p>This barrier also includes being unable to travel to appointments (e.g., not having a car, not having access to public transportation).</p>	<p>Choi et al. (2014)¹⁹⁴</p> <p>Hadley Strout et al. (2016)¹⁹⁵</p>

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BARRIER	DEFINITION, DESCRIPTION, OR EXAMPLE OF BARRIER	SAMPLES OF RESEARCH
Living situations and social settings that “normalize” substance misuse	<p>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.</p> <p>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.</p> <p>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.”</p>	<p>Castle et al. (2012)¹⁹⁶</p> <p>Klein & Jess (2002)¹⁹⁷</p> <p>White et al. (2015)¹⁹⁸</p> <p>Moos et al. (2011)¹⁹⁹</p>
Lack of social support, including social isolation or low social connectedness	<p>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).</p> <p>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.</p>	<p>Bremer et al. (2017)²⁰⁰</p> <p>Graham et al. (2014)²⁰¹</p>
Limited numbers of providers with knowledge of and commitment to working with older adults	<p>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.</p>	<p>Institute of Medicine (2012)²⁰²</p> <p>Bartels et al. (2014)²⁰³</p>
No coordinated services; limited access to behavioral health or social services across care settings or geographic regions	<p>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.</p> <p>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.</p>	<p>Institute of Medicine (2012)²⁰⁴</p> <p>Gage & Melillo (2011)²⁰⁵</p>

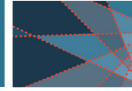
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BARRIER	DEFINITION, DESCRIPTION, OR EXAMPLE OF BARRIER	SAMPLES OF RESEARCH
Lack of case management or care management	<p>Case managers (or “care managers”) coordinate healthcare and behavioral health services across providers. When care is not coordinated, clients might not get access to the full range of treatments they need.</p> <p>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.</p>	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	<p>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).</p> <p>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.</p>	Kuerbis et al. (2014) ²⁰⁸
Loss, especially death of children, spouse, siblings, or close friends; also, loss of employment (e.g., forced retirement)	<p>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.</p> <p>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.</p>	<p>Stahl & Schulz (2014)²⁰⁹</p> <p>Kelly et al. (2018)²¹⁰</p>

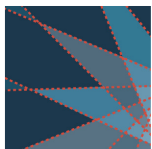
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BARRIER	DEFINITION, DESCRIPTION, OR EXAMPLE OF BARRIER	SAMPLES OF RESEARCH
Lack of health literacy	<p>“Health literacy” is a person’s ability to access, understand, and communicate about health-related information.</p> <p>Older people with low health 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.</p>	<p>Levy & Janke (2016)²¹¹</p> <p>Geboers et al. (2016)²¹²</p> <p>Findley (2015)²¹³</p>
Cultural norms	<p>Cultural norms can influence a person’s help-seeking behavior.</p> <p>For example, an older person whose culture discourages talking about mental illness or substance misuse may not seek help.</p> <p>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.</p>	<p>Royal College of Psychiatrists (2015)²¹⁴</p> <p>Barrio et al. (2008)²¹⁵</p> <p>Jimenez et al. (2013)²¹⁶</p>
Racial and cultural differences among older clients	<p>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.</p> <p>For instance, an older individual who does not speak English fluently may feel uncomfortable asking for help from a provider who speaks only English.</p>	<p>De Guzman et al. (2015)²¹⁷</p> <p>Barrio et al. (2008)²¹⁸</p> <p>Sorkin et al. (2016)²¹⁹</p>
Gender and sexual identity	<p>Like race and culture, older adults’ gender and sexual identity can affect whether they seek and receive help for substance misuse or mental illness.</p> <p>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.</p> <p>Older women are especially vulnerable to some barriers, like stigma, low income, or providers not recognizing their substance misuse.</p>	<p>Auldrige et al. (2012)²²⁰</p> <p>Koenig & Crisp (2008)²²¹</p> <p>Chrisler et al. (2016)²²²</p>

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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.

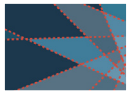
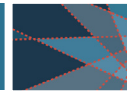


EXHIBIT 2.1. Key Terms

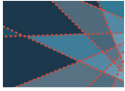
- **Addiction*:** The most severe form of SUD, associated with compulsive or uncontrolled use of one or more substances. Addiction is a chronic brain disease that has the potential for both recurrence (relapse) and recovery.
- **Age-sensitive:** Adaptations to existing treatment approaches that accommodate 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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*Continued*

- **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 Adults²⁴⁶

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. 375²⁵⁵

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

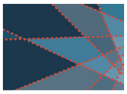
Older adults who misuse substances may not want to set abstinence as their goal. **Engaging in health risk reduction practices is an important and viable option** for older adults and is consistent with age-sensitive treatment practices.²⁶⁵ For example, medical providers can slowly taper older adults 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. 16²⁶⁸

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 adaptations 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}

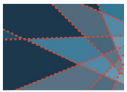
Social networks for older adults in recovery include caregivers, family, friends, faith-based communities, peer recovery support services, and mutual-help groups.

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

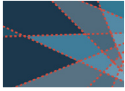
In addition, administrators need to be aware of state-level variance in policies and practices, which can dictate the parameters and limitations of a program's features and implementation process.

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.